HIV/AIDS Monitorship Questionnaire
(To be completed by the Infection Control Nurse)

DATE:_____

NAME:_____ **AGE:** _____ **SEX:**_ _____
ADDRESS:_____ _____ _____
PHONE NUMBER:_ **RACE:** _____

Lives In: Parent's Home Own Home ICF SLP I SLP II
CTH I CTH II Foster Home Other Describe_____

Functional Level: Mild Moderate Severe Profound

Does supervision (day to day) appear appropriate? Yes No
If no explain: _____
_____

How was HIV contracted? __
When was HIV diagnosed? __
Current symptoms:___
_____

Sexual orientation:_____ Sexually active?: Yes No

History of IV drug use? Yes No Sexually transmitted diseases?: Yes No

Local DHEC involved? Yes No If so, how: _____
_____

Physician involved? Yes No If so, name:_____
Followed by Infectious Disease Clinic in Community?
Yes No If so, name:_____

Other agencies involved? Yes No If so, name:_____
_____

Nutritional Status:_____
Allergies:____
Immunizations up to date?___
Current Medications:_____
Relevant Lab Work:_____
_____

Mental/emotional status at this time:
_____
_____

Has training in HIV/AIDS been done for the consumer?
Yes No If so by whom? _____

Recommended frequency of monitorship visits Monthly Quarterly

Signature of Infection Control Nurse Date